Appendix 12
Certification of Need (CON) Form for *Elective/Urgent* Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease (IMD) for Recipients Under Age 21
(Retain completed form in medical record)

ERO control # 1

Recipient Information

Recipient's name 2

Wisconsin Medicaid identification number 3

Date of Birth 4

Facility Information

Admitting facility name and address 5

Wisconsin Medicaid provider number 6 Admission date 7

The independent team that completes this form must:

- Not have an employment or consultant relationship with the admitting facility.
- Have competence in diagnosis and treatment of mental illness.
- Have knowledge of the recipient's situation.

We hereby certify the following:

- Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

8
Signature of physician Date signed

9
Complete name of physician (print) Credentials

10
Signature of other team member Date signed Credentials

Signature of other team member Date signed Credentials

11
Date of completion of CON form

Appendix 13
Completion Instructions for Certification of Need (CON) Form for *Elective/Urgent* Psychiatric/ Substance Abuse Admissions to Hospital Institutions for Mental Disease (IMD) for Recipients Under Age 21

1. ERO control number
Indicate the ERO control obtained by the hospital from the external review organization (ERO).

Recipient Information

2. Recipient's name
Enter the recipient's name from the recipient's identification card. The name in this element must match the name on the claim submitted to the Medicaid fiscal agent.

3. Recipient's Wisconsin Medicaid identification number
Enter the recipient's 10-digit identification number from the recipient's identification card. This identification number must match the identification number on the claim submitted to the fiscal agent.

4. Date of birth
Recipient's date of birth. The month, day, and year must be clearly indicated.

Facility Information

5. Admitting facility name and address
Enter the facility's complete name and address.

6. Wisconsin Medicaid provider number
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

7. Admission date
Enter the date that the patient was admitted to the hospital facility.

8. Signature of physician and date
The independent physician must sign and date this form. Initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is not acceptable. A nurse or other individual's signature is not acceptable.

9. Complete name of physician
Type or print the formal name of the physician.

10. Signature of other team member and date
Other members of the independent team must sign and date this form. Initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is not acceptable. No other individual may "sign for" the team member. Team members must state their credentials.

11. Date of completion of CON form
Enter the date that the CON process has been completed. If different CON dates are indicated on the form, the CON will be presumed to have been completed on the latest CON date indicated on the form.

Appendix 14
Certification of Need (CON) Form for *Emergency* Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease (IMD) for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission
(Retain completed form in medical record)

Please check (one):
1 ☐ Emergency admission
☐ Medicaid after admission

ERO control # 2

Recipient Information

Recipient's name 3

Wisconsin Medicaid identification number 4

Date of birth 5

Facility Information

Admitting facility name and address 6

Wisconsin Medicaid provider number 7 Admission date 8

Persons completing this form must be:

- Members of the interdisciplinary team responsible for the plan of care for this patient. (Interdisciplinary team is described in 42 CFR 441.156 and page 1F5-008 of this handbook.)

We hereby certify the following:

- Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

9
Signature of physician Date signed

10
Complete name of physician (print) Credentials

11
Signature of other team member Date signed Credentials

Signature of other team member Date signed Credentials

12
Date of completion of CON form

All requested information *must* be provided.

Appendix 15
Completion Instructions for Certification of Need (CON) Form for *Emergency* Psychiatric/ Substance Abuse Admissions to Hospital Institutions for Mental Disease (IMD) for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission

1. Admission
Indicate by placing a check mark in the appropriate box on the emergency CON form whether the patient was an *emergency admission* or the patient became *Medicaid eligible after the admission.*

2. ERO control number
Indicate the ERO control number obtained by the hospital from the external review organization (ERO).

Recipient Information

3. Recipient's name
Enter the recipient's name from the recipient's identification card. The name in this element must match the name on the claim submitted to the Medicaid fiscal agent.

4. Recipient's Wisconsin Medicaid identification number
Enter the recipient's 10-digit identification number from the recipient's identification card. This identification number must match the identification number on the claim submitted to the fiscal agent.

5. Date of birth
Recipient's date of birth. The month, day, and year must be clearly indicated.

Facility Information

6. Admitting facility name and address
Enter the facility's complete name and address.

7. Wisconsin Medicaid provider number
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

8. Admission date
Enter the date that the patient was admitted to the hospital facility. This date and the date that the patient became Medicaid-eligible may be different.

9. Signature of physician and date
The physician must sign and date this form. Initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is not acceptable. A nurse or other individual's signature is not acceptable.

10. Complete name of physician
Type or print the formal name of the physician.

11. Signature of other team member and date
Other members of the multidisciplinary team must sign and date this form. Initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is not acceptable. No other individual may "sign for" the team member. Team members must state their credentials.

12. Date of completion of CON form
Enter the date that the CON process has been completed. If different CON dates are indicated on the form, the CON will be presumed to have been completed on the latest CON date indicated on the form.

Attachment 3

COUNTY AGENCY CONTACTS REGARDING CHILDREN AT MMHI AND WMHI

COUNTY AGENCY_____

AGENCY DIRECTOR_____

Contact to Authorize Admissions_____

Contact to Inform of Emergency Detentions_____

Contact for Billing Status/Payment Responsibility_____

Submit this form to:

Janice Krall
Mendota Mental Health Institute
301 Troy Drive
Madison, WI 53704

Beverly Pezewski
Winnebago Mental Health Institute
P.O. Box 9
Winnebago, WI 54985- 0009

Submit this form to both facilities by February 28, 2003

Medicaid/BadgerCare HMO Contract Administrators

HMO Name	Contract Administrator and Address	Phone & Fax Number
Atrium Health Plan	Carroll Carlson Atrium c/o GHC of Eau Claire P.O. Box 3217 Eau Claire, WI 54702-3217	Phone: (888) 203-7771 Fax: (715) 836-7683 E-mail: ccarlson@group-health.com
Dean Health Plan	Mary Anderson Dean Health Plan, Inc. P.O. Box 56099 Madison, WI 53705	Phone: (608) 827-4018 Fax: (608) 827-4212 E-mail: mary.anderson@deancare.com
GHC of Eau Claire	Carroll Carlson GHC of Eau Claire P.O. Box 3217 Eau Claire, WI 54702-3217	Phone: (888) 203-7770 Fax: (715) 836-7683 E-mail: ccarlson@group-health.com
GHC of South Central WI	Carmella Glover Group Health Cooperative P.O. Box 44971 Madison, WI 53744-4971	Phone: (608) 828-4819 Fax: (608) 828-9333 E-mail: carmella_glover@ghc-hmo.com
Health Tradition Health Plan	Kim J. Stein Health Tradition Health Plan P.O. Box 188 La Crosse, WI 54602-0188	Phone: (608) 783-9508 Fax: (608) 781-9653 E-mail: stein.kim@mayo.edu
Managed Health Services	Sandra Tunis Managed Health Services Ins. Corp. 1205 South 70th Street, Suite 500 West Allis, WI 53214	Phone: (414) 345-4600 Fax: (414) 345-4624 E-mail: stunis@centene.com
MercyCare Insurance Company	Barb Johnson MercyCare Insurance Company P.O. Box 2770 Janesville, WI 53547-2770	Phone: (800) 752-3431 (608) 741-3345 Fax: (608) 752-3751 E-mail: bjohnson@mhsjvl.org
Network Health Plan	Sandra Tunis Network Health Plan 1205 South 70th Street, Suite 500 West Allis, WI 53214	Phone: (414) 345-4600 Fax: (414) 345-4624 E-mail: stunis@centene.com
Security Health Plan	Scott Polenz Security Health Plan of WI, Inc. 1515 St. Joseph Avenue P.O. Box 8000 Marshfield, WI 54449	Phone: (715) 221-9595 Fax: (715) 221-9500 E-mail: polenz.scott@marshfieldclinic.org

HMO Name	Contract Administrator and Address	Phone & Fax Number
Touchpoint Health Plan	Debbie Ludka Touchpoint Health Plan 5 Innovation Ct., P.O. Box 507 Appleton, WI 54912-0507	Phone: (920) 831-6837 Fax: (920) 831-6770 E-mail: debbie.ludka@thedacare.org
UnitedHealthcare of Wisconsin, Inc.	Julie Litza UnitedHealthcare of Wisconsin, Inc. 10701 West Research Drive Milwaukee, WI 53226	Phone: (414) 443-4527 Fax: (414) 443-4639 E-mail: julie_a_litza@uhc.com
Unity Health Plans	Kathy Ikeman Unity Health Plans 840 Carolina Street Sauk City, WI 53583-1374	Phone: (608) 643-1486 Fax: (608) 643-2564 E-mail: kathleen.ikeman@unityhealth.com
Valley Health Plan	Ami Wathke Valley Health Plan 2270 EastRidge Center P.O. Box 3128 Eau Claire, WI 54702-3128	Phone: (715) 836-1287 Fax: (715) 836-1293 E-mail: ami.wathke@cobalt-corp.com